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No. 93-1251

In the Supreme Court of the United States

OCTOBER TERM, 1994

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

REPLY BRIEF FOR THE PETITIONER

DREW S. DAYS, III
Solicitor General
Department of Justice
Washington, D.C. 20530
(202) 514-2217

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TABLE OF AUTHORITIES

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1. This Court recently held in *Thomas Jefferson University* v. *Shalala*, No. 93-120 (June 24, 1994), that the Secretary's interpretation of Medicare provider reimbursement regulations is entitled to substantial deference. The Court explained (slip op. 7-8):

> We must give substantial deference to an agency's interpretation of its own regulations. *Martin* v. *OSHRC*, 499 U.S. 144, 150-51 (1991); *Lyng* v. *Payne*, 476 U.S. 926, 939 (1986); *Udall* v. *Tallman*, 380 U.S. 1, 16 (1965). Our task is not to decide which among several competing interpretations best serves the regulatory purpose. Rather, the agency's interpretation must be given "controlling weight unless it is plainly erroneous or inconsistent with the

regulation." *Ibid.* (quoting *Bowles* v. *Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945)). In other words, we must defer to the Secretary's interpretation unless an "alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation." *Gardebring* v. *Jenkins*, 485 U.S. 415, 430 (1988). This broad deference is all the more warranted when, as here, the regulation concerns "a complex and highly technical regulatory program," in which the identification and classification of relevant "criteria necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns." *Pauley* v. *BethEnergy Mines, Inc.*, 501 U.S. 680, 697 (1991).

Respondent contends, however, that this deferential standard is inapplicable to this case, on the theory that the Medicare provider reimbursement regulations contain a "clear and unambiguous" (Resp. Br. 17) requirement that generally accepted accounting principles (GAAP) must be followed in all Medicare reimbursement determinations.[1] If the regulations *did* contain a "clear and unambiguous" requirement that GAAP be applied in all reimbursement determinations,

[1] Respondent errs in suggesting (Resp. Br. 19-20) that deference to the Secretary's interpretation of her regulations is unwarranted because a subordinate hearing panel within the Medicare reimbursement system (the PRRB) adopted a contrary interpretation. It is to the Secretary—not to an inferior administrative tribunal whose decisions are reviewed by the Secretary—that deference is due in the interpretation of the Secretary's own regulations. See *Martin* v. *OSHRC*, 499 U.S. 144, 152-153 (1991); *Sun Towers, Inc.* v. *Heckler*, 725 F.2d 315, 326 (5th Cir.), cert. denied, 469 U.S. 823 (1984).

the Secretary would of course be bound by that requirement. For the reasons explained at length in our opening brief (Pet. Br. 17-35), however, the contention that such an unambiguous requirement exists in the regulations is simply not correct. The regulations do not even mention GAAP, much less mandate the application of generally accepted financial accounting principles in every reimbursement context by "clear and unambiguous" language. Moreover, for the reasons we have previously explained (Pet. Br. 21-23, 30-35), it would be inconsistent with other statutory and regulatory Medicare reimbursement policies for the regulations to be interpreted in that fashion.

a. The more specific of the regulations at issue directs providers to supply the Secretary with "adequate cost data * * * based on * * * the accrual basis of accounting." 42 C.F.R. 413.24(a). This language does not mandate reimbursement in accordance with GAAP. It merely requires providers to keep adequate "financial and statistical records" so that—as the regulation states—such records will be "capable of verification by qualified auditors" of the Secretary. *Ibid.*

To the extent that this regulation has relevance to reimbursement determinations, its "plain language" does not require adherence to GAAP; it requires only that records be maintained and submitted under the "accrual basis of accounting." 42 C.F.R. 413.24(a). The term "accrual basis of accounting" is defined in the regulation to mean the method of accounting under which "revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid." 42 C.F.R. 413.24(b)(2). This regulatory description of the "accrual basis of accounting" precisely incorporates the dictionary

definition of that term, which distinguishes "accrual basis" accounting from "cash basis" accounting (under which revenue is reported only when it is actually received and expenses are reported only when they are actually paid). See *Random House Dictionary of the English Language* 13, 322 (2d ed. 1987); *Webster's Third New International Dictionary* 13, 346 (1986); *Kohler's Dictionary for Accountants* 16 (6th ed. 1983); *Black's Law Dictionary* 18-19, 196 (5th ed. 1979). The regulatory reference to "accrual basis of accounting" thus merely directs providers to submit cost information to the agency on the accrual basis, rather than on the cash basis, of accounting.

GAAP is a collection of accounting principles derived from alternative accrual accounting methodologies, but the terms "GAAP" and "accrual basis of accounting" are not synonymous. GAAP represents the consensus of the accounting profession as to which alternative applications of accrual basis accounting methodology are appropriate in specific contexts for financial reporting purposes. D.R. Carmichael, S. Lilien & M. Mellman, *Accountants' Handbook* §§ 1.5(a), 2.4(a), 2.5 (7th ed. 1991). GAAP is thus a subset, not an exhaustive list, of accrual accounting methodologies. By requiring in Section 413.24 of the regulations that providers employ the "accrual basis of accounting," the Secretary rejected cash basis accounting for record-keeping and reporting, but did not thereby abdicate to the accounting profession her discretion to determine which accrual accounting procedure best determines "the reasonable cost of services" (42 C.F.R. 413.9(a)) for Medicare reimbursement purposes in different factual contexts. See Pet. Br. 17-30.

The Secretary's reimbursement policy in Provider's Reimbursement Manual (PRM) § 233 for advance

refunding transactions is, moreover, fully consistent with the "accrual basis" accounting method. Accrual accounting recognizes that amortization is appropriate in some circumstances to properly match benefits to the periods to which those benefits relate. Financial Accounting Standards Board (FASB), Statement of Concepts No. 6, ¶¶ 144-149 (Dec. 1985). In the particular reimbursement context in which this case arises, the Administrator has explained that the lower interest costs resulting from respondent's refinancing "did not relate exclusively to patient care services rendered in the year of the loss" but "more closely related to the years over which the original bond term extended (the period over which the lower interest will be enjoyed)." Pet. App. 49a. See also *id.* at 51a; J.A. 17, 76; Admin. Rec. 312. The policy expressed in PRM § 233 thus represents a particularized application, not an abnegation, of accrual basis accounting.

b. Section 413.20(a) of the regulations likewise does not mandate that Medicare reimbursement determinations always be made in accordance with the generally accepted accounting principles employed for financial reporting purposes. This regulation requires that "[s]tandardized * * * accounting * * * practices * * * in the hospital and related fields" are to be followed in the preparation of data for use by the Secretary in arriving "at equitable and proper payment for services to beneficiaries." 42 C.F.R. 413.20(a). As we explain in our opening brief (Pet. Br. 25-27), this regulation is concerned with the starting point of the reimbursement process—the provision of accurate records by hospitals—and not the ending point of the Secretary's determination of "reasonable costs" for reimbursement purposes.

c. The Foreword to the Provider Reimbursement Manual, which was issued contemporaneously with the regulations, specifies that GAAP is applicable to reimbursement determinations only when no other reimbursement principle or policy in the PRM mandates or calls for a different result. Pet. Br. App. 1a-2a. The Secretary's administrative practice is consistent with that understanding of the regulations. From the initial promulgation of the regulations, the Secretary has consistently adopted the view that the GAAP version of accrual basis accounting is to be applied only when the Medicare reimbursement policies reflected elsewhere in the statute, the regulations or in the guidelines and policies articulated in the PRM do not require a different reimbursement rule. See *ibid.*; 41 Fed. Reg. 46,292 (1976).[2]

Respondent errs in relying (Resp. Br. 21) on *HCA Health Services Of Mid-West, Inc.* v. *Bowen*, 869 F.2d 1179, 1180 (9th Cir. 1989), for the proposition that the Secretary once advocated an inconsistent position. In *Bowen*, the court of appeals erroneously described the position of the Secretary as being that GAAP applies to reimbursement determinations "in the absence of any promulgated regulations" to the contrary. *Id.* at 1181. In fact, however, the Secretary's position in *Bowen* was that generally accepted accounting principles are applied in determining reasonable costs for Medicare purposes only when "neither the Medicare statute, the Medicare

[2] Other indications from the legislative history of the Medicare Act are also consistent with the view that GAAP does not control hospital reimbursement and that its relevance, if any, is simply to provide "an orderly procedure of reporting" costs by hospitals. Resp. Br. 24 n.8, quoting American Hospital Ass'n, *Principles of Payment For Hospital Care* 6, 7 (rev. Aug. 1963). See Pet. Br. 20-21 & n.11.

regulations, nor the Secretary's guidelines specifically address the allowability of" a particular cost (Appellee's Brief at 14, *HCA Health Systems of Mid-West, Inc.* v. *Bowen*, 869 F.2d 1179 (9th Cir. 1988) (No. 88-5601). The position of the Secretary in his brief in *Bowen* was consistent with (and cited, at 15) the Foreword to the PRM, which states that, "[f]or any cost situation that is not covered by the [PRM's] guidelines and policies, generally accepted accounting principles should be applied." Pet. Br. App. 2a.

The Secretary has not disputed that GAAP provides standard accounting rules that are useful in determining proper Medicare reimbursement when the regulations and the PRM do not otherwise call for a different approach. See Pet. Br. App. 1a-2a. The Secretary, however, has plainly *not* taken the position that her regulations require application of GAAP for reimbursement purposes when Medicare reimbursement policies depart from GAAP financial reporting principles in particular situations. See Pet. Br. 30-35.[3]

[3] *Amici* American Hospital Association, et al. (AHA) contend that the Secretary has sometimes insisted that GAAP is an inflexible reimbursement requirement. The instances cited by amici, however, primarily concern decisions by the PRRB (AHA Br. 14-15 & n.10), whose view on this issue has been rejected by the Secretary. See Pet. App. 11a-14a; note 1, *supra*. The other administrative decisions principally cited by amici involved (i) affirmance of a PRRB decision on its facts (*Brotman Memorial Hosp.* v. *Blue Cross/Blue Shield*, [Oct. 1980 - July 1981 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 30,922, at 9839 (Dec. 8, 1980)), and (ii) the question whether the provider had incurred a cost that could be "recorded as such in the provider's financial statements" (*Biscayne Medical Center* v. *Blue Cross/Blue Shield*, [Oct. 1982 - April 1983 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 32,304, at 9499 (Nov. 5, 1982)). In neither

d. In sum, neither the "plain language" of the regulations, the Secretary's practice under the regulations, nor any "other indications of the Secretary's intent at the time of [their] promulgation" (*Thomas Jefferson University* v. *Shalala*, slip op. 7-8) requires the conclusion that the agency *must* follow GAAP in all reimbursement determinations under the Medicare Act. Under this Court's consistent decisions, the Secretary's choice "among * * * competing interpretations" of her regulations is therefore entitled to "controlling weight" (*id.* at 7). See also *Udall* v. *Tallman*, 380 U.S. 1, 16 (1965); *Unemployment Compensation Commission* v. *Aragon*, 329 U.S. 143, 153-154 (1946).

Moreover, as we explain in our opening brief (Pet. Br. 21-23), the ultimate objectives of financial reporting and Medicare reimbursement determinations are markedly different. The Secretary's conclusion that the accounting principles adopted as GAAP for financial reporting purposes are not binding in determining the "reasonable cost of [Medicare] services" (42 C.F.R. 413.9(a)) is thus "not only a plausible interpretation of the regulation; it is the most sensible interpretation the language will bear" (*Thomas Jefferson University* v. *Shalala*, slip op. 9).

2. The implementation of the reimbursement regulations contained in PRM § 233 is not a substantive rule. It is an elaboration of the reimbursement standards set forth in the existing regulations.

The Secretary has statutory authority to provide, by regulation, for the reimbursement of the "reasonable

of those decisions did the Secretary take the position that GAAP is binding for all reimbursement determinations.

cost" of provider services. 42 U.S.C. 1395x(v)(1)(A).[4] She has invoked that authority by promulgating regulations that provide for reimbursement of "the reasonable cost of services * * * related to the care of [Medicare] beneficiaries" and, in particular, of capital-related provider costs that are "appropriate and helpful in * * * maintaining the operation of patient care facilities." 42 C.F.R. 413.9(a) and (b)(2). Reimbursable capital costs include "[n]ecessary and proper interest" and other costs associated with the issuance of capital indebtedness, such as the costs involved in this case. See 42 C.F.R. 413.130(a)(7) and (g); 42 C.F.R. 413.153; Pet. Br. 7.[5]

[4] Although respondent quotes extensively from 42 U.S.C. 1395hh(a) (see Resp. Br. 2, 46-47), respondent ultimately concedes that the rulemaking requirements of that statutory provision were enacted after PRM § 233 was issued and have no application to this case. Resp. Br. 17 n.15. See Pub. L. No. 100-203, § 4035(a)(3) and (b)(2), 101 Stat. 1330-77 to 1330-78.

[5] *Amici* Mother Frances Hospital and Osteopathic Medical Center of Texas contend that Sections 413.130(a)(7) and (g) of the regulations are irrelevant to this case because they were promulgated after PRM § 233 was issued. Mother Frances Br. 16-17, citing 48 Fed. Reg. 39,752, 39,809-39,810 (1983). The cited *Federal Register* notice, however, merely reorganized and clarified the preexisting regulations that had authorized reimbursement of capital-related costs, such as interest and "other costs related to * * * capital expenditures." See 42 C.F.R. 405.402(c), 405.419, 405.435 (1982). *Amici* also take issue with the Secretary's reliance upon regulations governing the reimbursement of interest expenses, claiming that such regulations "say nothing about * * * advance refundings." Mother Frances Br. 17. The capital charges at issue in this case, however, represent an accounting "loss" incurred at a given time to save interest expenses in the future. See Pet. App. 47a-48a. The loss associated with respondent's advance refunding transaction represents a component

The Secretary's regulations further require that, in allocating the "reasonable cost" of a service provided over more than one accounting period, the timing of the reimbursement is to be matched to the timing of the provision of that service to Medicare program beneficiaries. This requirement is reflected in the regulations that require that payments made to a hospital in a particular year reflect "the amount determined * * * to be the *actual cost of services furnished to beneficiaries during the year.*" 42 C.F.R. 413.9(b)(1) (emphasis added). See also 42 C.F.R. 413.9(a), 413.60(b); Pet. Br. 31-32. This requirement implements the statutory prohibition against cross-subsidization, which mandates that Medicare funds not be used to subsidize non-Medicare patient services. 42 U.S.C. 1395x(v)(1)(A). See Pet. App. 49a-50a. As the Administrator explained in this case, the amortization of advance refunding costs over the remaining term of the original debt is appropriate to ensure that the reimbursement permitted in any single year reflects the "actual cost of services" furnished to Medicare beneficiaries in that year (Pet. App. 49a):

> By amortizing the loss to match it to Medicare utilization over the years to which it relates, the program is protected from any drop in Medicare utilization, and the provider is likewise assured that it will be adequately reimbursed if Medicare utilization increases.

The Secretary's regulations thus provide authority to reimburse capital-related costs and to match such reimbursement to the periods benefited. As all parties

of interest costs, as a "cost incurred for the use of borrowed funds" (42 C.F.R. 413.153(b)).

agree, however, the regulations do not specify how those general principles apply in the particular context of an advance refunding transaction. PRM § 233 exists to provide guidance in precisely this situation. It thus represents a "statement of policy" (*Lincoln* v. *Virgil*, 113 S. Ct. 2024, 2034 (1993)), or an "interpretative rule[]," as a "statement[] as to what the administrative officer thinks the statute or regulation means" when applied in particular situations. *Gibson Wine Co.* v. *Snyder*, 194 F.2d 329, 331 (D.C. Cir. 1952). It is not a "substantive rule," for it does not have the force and effect of law or regulations (Pet. Br. App. 1a; 42 C.F.R. 405.1867) and does not create "new law, rights or duties." *General Motors Corp.* v. *Ruckelshaus*, 742 F.2d 1561, 1565 (D.C. Cir. 1984) (en banc), cert. denied, 471 U.S. 1074 (1985).[6] Instead, PRM § 233 "merely clarif[ies] or explain[s] existing law or regulations." *Seldovia Native Ass'n* v. *Lujan*, 904 F.2d 1335, 1347 (9th Cir. 1990).

Both courts below agreed with the Secretary that amortization of respondent's "advance refunding" costs "squares with economic reality." Pet. App. 8a, 32a. As the Administrator noted, respondent's "loss is a cost of rendering patient care over several years" and therefore should be amortized "over those periods which benefit from the reduced interest rate" (Pet. App. 49a, 51a). The Administrator explained (*id.* at 51a):

[6] Respondent errs in claiming that PRM § 233 "makes a substantive change in [the] methods of reimbursement." Resp. Br. 47. Medicare has always required that any significant loss resulting from "advance refunding" transactions be amortized. See *Washoe Medical Ctr.* v. *Aetna Life & Casualty*, [Oct. 1980 - July 1981 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 31,073, at 10,336, 10,338 (P.R.R.B. May 27, 1981).

> [T]he Provider was not required by the refinancing to make any immediate out-of-pocket payment to satisfy the refinancing loss. Instead, the loss was absorbed by the greater amount borrowed * * *. Thus, the Provider has not actually experienced an immediate unreimbursed outflow of funds. Reimbursement of the loss over a period of years, therefore, will more accurately allocate the Provider's refinancing costs, and, at the same time, more accurately reflect its current costs.

As a rational interpretation and application of the Medicare statute and regulations, PRM § 233 is entitled to "controlling weight." *Thomas Jefferson University* v. *Shalala*, slip op. 7.[7]

[7] Respondent contends (Resp. Br. 36-37) that amortized reimbursement of advance refunding costs departs from the regulatory provision that specifies that "[i]n formulating methods for making fair and equitable reimbursement for services rendered [to] beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period" (42 C.F.R. 413.5). Respondent's contention confuses apples with oranges. In many contexts, costs incurred currently to provide benefits over several periods (*e.g.*, capital costs) are routinely and appropriately amortized to match the period of reimbursement to the period in which services are provided to Medicare beneficiaries. The requirement that "current costs," rather than "costs of a past period," be considered in reimbursement determinations merely requires that inflation (or deflation, if that should occur) be taken into account. It does not prevent application of amortization, or the proper matching of reimbursement to the provision of services, as respondent incorrectly suggests. For example, no one disputes that bond issuance costs incurred currently in the course of issuing new debt are to be amortized and reimbursed over the period of the life of that debt. See Pet. Br. 7; Pet. App. 3a-4a. This case simply concerns whether that same amortization principle also applies i-

3. Even apart from the question of the validity of PRM § 233, the order at issue in this case should be sustained. This case concerns the validity of a particular reimbursement order; it is not a facial challenge to the validity of an interpretative rule or statement of policy. The Secretary's rational application of the reimbursement regulations to the facts of this case is supported by substantial evidence. See Pet. Br. 34-35; Pet. App. 8a. The Secretary's conclusion that respondent's "loss" on defeasance relates to more than one accounting period and requires amortization—to properly match reimbursement with varying patient service levels over time—is not arbitrary, capricious, an abuse of discretion, or inconsistent with the agency's regulations. The order requiring amortized reimbursement of respondent's advance refunding costs should be sustained for this reason alone. See Pet. Br. 37.

For the foregoing reasons, as well as those stated in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted.

DREW S. DAYS, III
Solicitor General

JULY 1994

Medicare reimbursement determinations to the accounting "loss" associated with an advance refunding transaction.